which possesses none of these disadvantages, exists in the combination made by Dragendorff and Massing of cantharidin with alkalies. M. Delpech employs the cantharidinate of potash, which is very volatile, and possesses in a high degree the blistering power; from an alcoholic solution of cantharidin containing 2 grammes in 150, about 1.6 grammes fall on the addition of a concentrated solution of alkali of a precipitate which is absolutely insoluble in water. The best formula for the application of the preparation is gelatine 2.09, water 10, alchohol 10, cantharidinate of potash 0.20, and glycerine 9.5. The mass should be equably spread on a thin layer of gutta-percha, so that each square inch should contain a definite proportion of the salt; it may of course be made stronger or weaker at will.—*Practitioner*, Aug. 1870, from *Centralblatt*, No. 27.

16. *Report of the Committee of the Royal Medical and Chirurgical Society appointed to investigate Boin's and Pacini's Method of restoring Suspended Animation.*—The means adopted by the committee for pursuing the inquiry were by experiment upon the dead human body; and in order to test the relative merits of the methods proposed, they were contrasted with the plan adopted by Dr. Silvester. Details of a large number of observations were given in the report. The conclusions at which the committee arrived from these observations might be summed up as follows. It appeared that more air is introduced, as a rule, by traction from the shoulders than from the forearms and arms. Nevertheless, in the amount of air introduced, there is a greater difference when the same method is adopted with different bodies than there is between the two plans when practised upon the same body; this great difference being chiefly due to the size of the body, especially the amount of fat, the mobility of the walls of the chest, and the rigidity of the muscles. By either plan, the committee were of opinion that a sufficiently large quantity of air is without difficulty introduced. And it might be observed that in either case, on an average, more air is changed than in the act of ordinary tranquil respiration. In estimating the relative merits of the two plans, they were anxious to observe that other considerations are involved than that of the absolute and comparative quantity of air changed. They were unanimously of the opinion that the method advocated and practised by Dr. Bain was but a modification of the plan usually known as Silvester's, and involved no new principle of action. Indeed, in his more recent publications, Dr. Silvester had not limited his point of traction to any one part in particular of the forearm or arm. They were therefore of opinion that, in the great majority of cases, it is of comparatively little moment which method of manipulation is practised, provided the common principle on which both are founded be fairly carried out.—*British Medical Journal*, July 30, 1870.

MEDICAL PATHOLOGY AND THERAPEUTICS, AND PRACTICAL MEDICINE.

17. *Revaccination.*—The importance of revaccination has now become fully recognized by the highest authorities in the profession; but, unfortunately, it is not recognized by the public.

M. Depaul, on behalf of a committee of the Academy of Medicine, appointed to reply to a request made by the Minister of the Interior, for the opinion of that learned body, as to the value of revaccination, read the following, which was adopted:—

"The Academy of Medicine believes it to be useful to make public the following declaration, which it commends to the attention of the government and of the public.

"Vaccination is a preservative from smallpox.

"Nevertheless, after a certain period, revaccination is indispensable to assure complete immunity against contagion.

"Revaccination is absolutely exempt from danger. The Academy formall repudiates all that has been said and published to the contrary.

"Revaccination may be useful at all ages.

"It may be performed without inconvenience during the prevalence of an epidemic. Moreover, it is certain that, in small localities, in families, boarding-houses, or in collections of persons, it will effectually arrest a commencing epidemic.

"The existing epidemic in Paris and other places has furnished the most convincing proofs of the preservative power of revaccination.

"In different army corps, and especially in the Garde de Paris, in many public and private establishments, and in some of the municipal schools, variola has been arrested by revaccination. Finally, the latest statistics, particularly those from the civil hospitals of Paris, prove most positively that very few revaccinated persons are attacked with smallpox, and that of those who were none died.

"It is then of the utmost importance, for the interest of individuals and of the public, to encourage, by every possible means, the practice of revaccination."—*Révue de Thérapeutique Médico-Chirurgicale*, July 15, 1870.

The following statement from the *Lancet* (June 25, 1870) fully confirms the above view:—

"At the smallpox hospital (London) every nurse is revaccinated before entering on her duties; and, during thirty-four years, not one of these nurses has contracted smallpox. Some years ago, when the new smallpox hospital was built, and when many workmen were regularly employed there for several months after patients were received, the great majority of these workmen, who submitted to revaccination, entirely escaped smallpox, while two cases of the disease did occur among the few who were not revaccinated. Reasoning, not from theoretical considerations, but on the broad and firm ground afforded by large practical experience, Dr. Seaton advises that every child should be revaccinated at or about the age of puberty, or still earlier when smallpox is prevalent, or when the original vaccination was imperfect; and that the revaccination should be from arm to arm, and performed with the greatest possible care."

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18. *Anosmia.*—The *Archives Générales de Méd.* for April last contains some interesting researches by Dr. Notta, on the loss of the sense of smell. The author has collected twenty-four cases of this affection and from the data which the study of these cases furnishes it is evident that anosmia may result from very different causes.

It may be congenital, and due to an absence of the olfactory nerves.

It may be only a symptom of a more serious disease, as of a cerebral tumour, exostosis, or caries of the frontal bone, which produces the destruction, compression, or alteration of the first pair of nerves.

It may result from atrophy of the same nerves.

In other cases in which it constitutes the sole disease, Dr. N. proposes to term it essential, inasmuch as it occurs without appreciable cause.

It may be a sequel of falls on the head, complicated or not with fracture of the cranium, and then Dr. N. terms it traumatic.

It supervenes sometimes to a coryza either more or less prolonged or complicated with influenza, sometimes to repeated attacks of coryza.

Finally, it may occur from external causes independent of the condition of the nerves, as absence of the nose, contraction of the nasal fossæ, and polypus of the nose.

The loss of smell manifests itself differently, according to the cause which produces it. Sometimes, as in atrophy of the olfactory nerves, or as the sequela of repeated coryzas, it comes on slowly and becomes complete only after a lapse of years. Sometimes, when occasioned by an injury, or by a strong impression on the olfactory nerve, as in the case related by Graves, it may occur suddenly.

Physiologists inform us that the taste of certain articles may be perceived independently of the sense of smell, such as sugar, salt, acid, sweet, bitter; on the contrary, the integrity of both senses is necessary to enable us to distinguish others, such as the flavour and the aroma of food and drinks. Most of the observations collected by Dr. N. confirm this, but there are many exceptions to this law and in which the sense of taste was preserved, while that of smell was completely abolished. Such cases have occurred under very different conditions—in one case after anosmia from a fall on the head, in another where it was consecutive to a coryza complicated with influenza, once after repeated coryzas, and finally, in a case of polypus of the nasal fossæ. Dr. N. does not seek to explain this anomaly, but is satisfied in pointing out what was well known before, that pathological facts and experimentation do not always lead to exactly the same results.

The duration of anosmia varies with the cause which produces it. When anosmia results from atrophy of olfactory nerves, or those nerves are destroyed by a tumour, it is incurable. But when it is caused by injury or by coryza, although it may be permanent, in numerous cases the sense has been recovered after a period varying from three weeks to seven months.

As to the treatment of this affection Dr. N. has not been able to throw any light on the subject. He has tried veratria, sternutatory powders, etc., without the least benefit; and where recovery has taken place it has been due to the powers of nature.

19. *Mucous Disease.*—Dr. WALTER WHITEHEAD, of Manchester, read a paper on this disease, at the late meeting of the British Medical Association. Though noticed by some of the ancients, and described by a few more modern medical writers, it has received only occasional recognition in our best standard medical works.

This disease is characterized by the secretion of mucus of an abnormal composition on mucous surfaces, in which condition the mucus is prone to consolidate into masses, shreds, or tubular casts. These secretions form and exfoliate periodically, each exfoliation being critical and immediately followed by an amelioration of the symptoms which aggravate it up to this point. This critical period is accompanied by pains of a spasmodic character and of variable intensity. The subjective symptoms are those of a most distressing nervous nature. The disease, read in accordance with modern research, may be formulated as follows: 1. The proximate cause of the symptoms referable to this disease is the hypersecretion and accumulation of mucus on the free surface of the mucous membranes; such accumulations sheathe and prevent the healthy performance of the functions natural to the part, and thus induce immediate and remote results, the effects of such suppressed functions. 2. That this hypersecretion indicates a want of balance between nerve-force and germinal matter. 3. That the nerve-force is perverted by irritation. 4. That the exciting causes are numerous. 5. That it is a character of mucous secretions under the influence of irritation for its cell elements to increase, and its viscidity to diminish. 6. And that, in the disease in question, the prolific cell-formations become entangled in the albuminous fluid in which they are found, and present the membranous structures before referred to. The principal points in the treatment are as follows: 1. Discover and counteract any cause either in direct contact or in the immediate vicinity of the secreting surface which can be traced as a source of irritation. 2. Reinvigorate the strength, and allay the nervous irritability. 3. Remove the accumulated mucus. 4. Prevent, by topical application, its reformation. Such is a sketch of a disease, most serious in its import to the patient, and of far from unfrequent occurrence. True, the treatment is still in its tentative stage, but we are clearing the way for sounder views on the subject, by accurately laying down the causes and symptoms of a malady which one cannot doubt is constantly mistaken for one of the hydra forms of dyspepsia, and by the erroneous treatment resulting from this mistake, the first or curative stage of the disease is allowed to pass into the latter and more lethal forms.—*Lancet*, Aug. 20, 1870.

20. *Stertor, its Pathology and Treatment.*—In a paper by Dr. R. L. BOWLES, communicated to the Royal Medical and Chirurgical Society by Mr. Cæsar

Hawkins, the definitions of the three forms of stertor (palatine, pharyngeal, and mucous stertor) treated of in vol. xlviii. of the *Medico-Chirurgical Transactions* are referred to, as well as a "laryngeal stertor" in chloroform poisoning spoken of by Professor Lister. Case 1 illustrates the cessation of stertor on placing the patient on her side, a gradual improvement subsequent to this, the return of stertor and impending death when she was placed on the opposite side, the instant relief on assuming her original position, and a return to consciousness coincident with the cessation of stertor. The causes of these conditions are discussed, and cases are given illustrating the necessity of always placing the paralyzed side downwards, and of never changing it to the opposite side; for the lung of the paralyzed side becomes loaded with a mucous fluid, which gravitates to the opposite lung whenever the patient is placed with the opposite (*i. e.*, sound) side downwards, and in its passage across the trachea the mucus becomes churned up into foam by the ingoing air, causing mucous stertor, great dyspnœa, and, if not removed, death. It is shown by experiment that these conditions may be induced and removed at will in apoplectic cases, and the practical applications of these principles are pointed out. Cases are related demonstrating the successful application of these principles in respect of the removal of stertor, as well as some cases of recovery from apoplexy after the stertor has been removed. Their application also to bronchitis, convulsions, epilepsy, hæmoptysis, drowning, chloroform poisoning, and all allied conditions, is pointed out, and the following conclusions are deduced: 1st. That a "laryngeal stertor" may be added to the three forms formerly defined. 2d. That the three forms of stertor which have the most important connection with the apoplectic state are the palatine, pharyngeal, and mucous stertor. 3d. That the three varieties, whatever their remote causes, are the immediate results of a local mechanical condition, which may always and at once be changed, to the great relief of the patients, and sometimes their permanent recovery. 4th. That it is necessary to keep the patient on one side, and that the paralyzed side should be downwards. 5th. That mucus and other fluids gravitate into and fill up the lower lung, and therefore if the sides be reversed, the mucus will find its way into the opposite lung. 6th. That the fluid crossing from the large bronchi of one lung to that of the other becomes churned into foam, and causes dangerous obstruction to the respiration. 7th. That the lung is not injured by remaining inactive, and filled with mucus for a long period. 8th. That these principles apply to all conditions in which mucus or fluid exists in either or both lungs, and also to all conditions allied to the apoplectic, whether there be fluid or not.—*Medical Times and Gaz.*, July 30, 1870.

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21. *Hæmophilia.*—Dr. ASSMANN, of Berlin, in his *Inaugural Dissertation*, 1869, gives an account of a number of individuals affected with irrepressible hemorrhage, who are known in popular language as *bleeders*. All belonged to the same family, the history of which Dr. A. was able to trace upwards through four consecutive generations. All of the patients, eight in number, were attacked at a somewhat early period of their infancy, and were of the male sex, all but one of mothers, of a lineage, who had never suffered from the disease. It would seem, then, that the predisposition to the form of hemorrhage referred to is transferred only to the male offspring. The repeated microscopical examinations made of the blood discharged in some of the cases referred to by Dr. A., give precisely the same results as was already announced by Grandidier—that is, about 1500 red corpuscles to every one of white.—*Centralblatt f. d. Med. Wissenschaften*, May, 1870. D. F. C.

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22. *Notes of Cases of Relapsing Fever.*—Dr. CLAUD MUIRHEAD read a paper entitled as above before the Medico-Chirurgical Society of Edinburgh, and which was subsequently published in the *Edinburgh Medical Journal* for July, 1870. The author endeavours to show that contagion, rather than infection, is the means by which this disease is propagated; that the period of incubation extends from five to ten days; that the occupation of the persons seemed in no way to predispose individuals to be attacked by it; that, out of the forty cases which were admitted to the fever wards, 60 per cent. were under the age of 20;

that the number of males, as compared with females, was as four to one, and of this number about 77 per cent. were of Irish extraction. From careful and minute inquiries into the circumstances of the patients admitted into hospital with this disease, and from personal inspection and measurement of the cubic space of those houses where large numbers of them lived, combined with this important fact, that not one of these people was out of work when seized with this complaint, he felt himself warranted in concluding that *over-crowding* has quite as much to do with the generation of relapsing fever as *destitution*—infinitely more with its propagation; and, in those cases which have this year presented themselves at the Infirmary, much more to do with it as an exciting cause.

He then detailed the various symptoms presented. A decided rash was observed only in one case, resembling the eruption observed in measles, rather than that seen in typhus fever. But in many cases a very marked prominence and erection of the hair-follicles, especially over the abdomen, thorax, and thighs, was present, which continued until the sweating stage supervened. Sudamina were almost invariably met with in the second crisis, seldom or never with the first. The temperature was most carefully noted in every case, and charts were exhibited showing the rapid and sudden fluctuations observed at the critical periods. During the first paroxysm, it ranges from 102 deg., the lowest point observed, to 106.2 deg. Fah., the highest point noted; the evening temperature usually exceeding that of the morning, and sinking at the crises quite suddenly to two or three degrees below the standard of health. The lowest point noticed was 92 deg. Fah., which occurred at the crisis of the first relapse. In this case, the temperature fell no less than thirteen degrees in twenty-four hours.

The spleen was uniformly found to be enlarged; and in the only fatal case, which occurred in a man of 59, from sudden syncope, it was found stuffed with clots and coagula. The number of white blood-corpuscles was found to be largely in excess of what is observed in healthy blood; the serum appeared to be increased; the red corpuscles were altered in character, and adhered to each other in irregular masses; and little granules were observed floating in the serum. The spleen diminished very decidedly during the remission of the fever.

As to treatment, nothing was found to be of the slightest use in warding off the relapse. Quinia was tried both by Dr. Fraser and Dr. Muirhead, by the mouth and subcutaneously, in combination with iron and with nux vomica. In one case, seventy grains were given in divided doses, during the three days before the *relapse*, with no effect. In another case, 110 grains were administered during the four days previous to the expected *relapse*, by which cinchonism in all its forms was fairly induced, yet still the inevitable relapse made its appearance.—*British Medical Journal*, August 6, 1870.

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23. *Recurrent* (*Relapsing*) *Fever; Crisis and Delirium.*—Dr. FRANTZEL states (Virchow's *Archiv*, 1869) that, in 100 cases of recurrent fever which fell under his observation, in Fraube's Clinic, during the month of December, 1868, and up to February, 1869, in one case the disease terminated without crisis. In 4 cases the crises set in at some period during the interval between a regular and irregular day; so that it was very difficult to fix the exact time of its occurrence. In 75 cases the commencement of which was well marked by a decided chill; 47 times the crisis took place upon an irregular day (3–13), and 28 times upon a regular day (4–12): the most frequently (24 times) upon the 7th day; upon the 5th day 17 times, and upon the 6th day 16 times. The relapse in the 100 cases was not noticed 8 times, and in 27 instances the commencement of the recurrent attack could not be determined with certainty. Of the remaining 65 cases, in the greater number, namely 17, it occurred on the 15th day—then on the 12th and 13th days (respectively 10 and 9 times), and only 14 times on one of the critical days of Hippocrates. The crisis of the relapse period in 34 cases happened on an irregular day (3–9), reckoning from the commencement of the relapse; in 31 cases it occurred on regular days (2–6) most frequently on the 4th, 5th, and 3d days, namely in 24, 21, and 11 cases respectively.

As a basis of diagnosis for recurrent fever, may be taken, the rapid course of the crisis, which, unlike that in pneumonia and intermittent fever, is, in most instances, completed in from 6 to 8 hours, often even in 4; in conjunction with great reduction in the temperature of the surface, and in the frequency of the pulse. The lowest depression of the temperature was 5° R.; often it was 7° R. The lowest depression of the pulse was to 40 strokes in the minute; in one case it fell to only 80 strokes. The same depression of temperature and decreased frequency in the pulse, is observed during the period of relapse; usually the recurrence of the disease takes place before either the temperature or the pulse have resumed their normal grade.

Delirium, Dr. F. observed in his 100 cases, only 12 times during the exacerbation of the fever, and as many times also during or immediately after the period of crisis, and 3 times on the day subsequent to the decline of the fever. Neither the duration of the delirium, observed during the height of the fever, nor its intensity, was very considerable; it usually terminated as the febrile delirium of other diseases. Very different is the delirium which in relapsing fever sets in during or after a crisis has occurred. It either assumes then the character of a furious delirium tremens, or of a stiller form, with occasionally more or less indistinct muttering, prompted by some prominent idea; in some cases it is so slight as to be readily overlooked. Both these forms of post febrile delirium are to be viewed as the products of inanition, as is the case in the delirium which follows the close of other acute diseases, and which even in those who have not been guilty of an abuse of intoxicating drinks, is identical in form, so often, with delirium tremens. The suspended nutrition during the continuance of the fever, the critical discharges, and the defective action of the heart readily explain the occurrence of this form of delirium after relapsing fever. It is to be subdued by the same means as when it occurs in cases of debility from non-nutrition, etc., in other diseases (pneumonia, phthisis, etc.); the employment, namely, of opium, or morphia. Of the subcutaneous administration of the latter, Dr. F. speaks in terms of commendation.—*Centralblatt f. d. Medicins. Wissenschaft.*, May 7, 1870. D. F. C.

24. *Pathology and Treatment of Scarlet Fever.*—Dr. Renfrew, of Glasgow, read a paper on this subject before the British Medical Association. He stated that scarlet fever is one of the zymotic diseases, which diseases are produced by an organized substance entering the body, which has the power of multiplying itself. In multiplying itself the blood is disordered, the nervous system deranged, the circulation quickened, and the secretions and excretions are changed. The poisons of the zymotic disease are not thrown off by the usual eliminating organs, but each poison is eliminated by a particular part of the body—smallpox by the skin, cowpox at the point of introduction, enteric fever by the lower part of the ileum, scarlet fever by the fauces and nose. When the poisons are thrown off there is always irritation and inflammation. As the poison of scarlet fever is thrown off by the fauces and nose, a large portion must pass into the stomach to be reabsorbed, intensifying and prolonging the disease. The remedies given in scarlet fever should be those that will destroy the poison; moderate and assist physiological changes. To accomplish these ends a mixture of chlorate of potash and tincture of steel is given, which contains chlorine, muriatic acid, iron, and chlorate of potash. The chlorine destroys the poison; the acid supplies acid to the blood, which is in a subacid condition; the iron improves the red disks, which are in a black and melanosed condition; the chlorate of potash supplies oxygen, to assist in oxidizing the disintegrated material that is floating in the blood.—*Lancet*, Aug. 20, 1870.

25. *Delirium in Scarlet Fever.*—Dr. J. K. Spender observes (*British Medical Journal*, July 16, 1870) that there is no disease, as asserted by Heberden, in which the patient is more apt to be delirious, and with less danger, than in scarlet fever. Speaking broadly, the delirium which may happen in scarlet fever is of two distinct orders: (*a*) the delirium of adults, occurring early in the history of the disease, and usually an index of high fever; (*b*) the delirium of children, occurring later in the disease, and often arising out of some sudden

impairment or stoppage of renal function. Now, the delirium of the adult fever, always excepting that which is associated with the puerperal state, may be left pretty much alone, so far as concerns the meddlesomeness of starving, purgatives, and antimony. In the case of a married lady who, in the spring of 1864, caught scarlet fever from an only child whom she nursed with most affectionate zeal, active delirium lasted for nearly sixty hours. I supported her with frequent small injections of milk and beef-tea, each injection containing ten drops of laudanum. When the patient suddenly rallied from her delirium, she seemed, *quoad* fever, nearly well. If a similar case were to come under my care now, I should cautiously try the subcutaneous injection of morphia, or, at least, try to get the patient to take hydrate of chloral, dissolved in a large bulk of water.

The delirium of children is often of much more serious import. It may be epileptiform in type, and may merge into coma with very little warning. The narrative of a very apposite case will probably be better than any dry description. On March 9, 1865, I began attendance on a case of scarlet fever in a young lady, ten years of age. The case was moderately severe, but everything went on absolutely well until about the twenty-fourth day, when I first noticed that the urine was very red. Remember Dr. Andrew Anderson's axiom, that it is "of more importance to examine the urine than to feel the pulse of a convalescent from scarlet fever." During the week ending Saturday, April 8, the urine was very red every day, but it was not scanty, and the small amount of albumen in it was sufficiently accounted for by the presence of the blood. There were no symptoms of any other kind announcing danger; and unfortunately in those days one did not use the thermometer as a daily companion as we do now, or doubtless it would have told its tale. The weather was beautifully warm and fine, as it was, indeed, all through the month. Early on Sunday morning, April 9, I was suddenly called to see the child, and I found her insensible, and strongly convulsed; the breathing stertorous, and the extremities cold. I adopted, without a moment's delay, an old-fashioned treatment, but it was perfectly successful. The head was shaved, and a small blister placed on the scalp; as soon as enough consciousness returned to allow deglutition, half a drachm of compound scammony powder was given every six hours until ample purgation resulted; and a hot bath was administered in the evening. On Monday, April 10, consciousness had partly returned, and there had been no convulsions since the previous evening. Only milk food was allowed, with abundance of toast and water as a drink. Absolute rest in bed was enjoined for a week, when the urine had become normal in colour and specific gravity, and was quite free from albumen; occasional hot bran poultices were applied to the loins. There was no subsequent interruption to perfect recovery.

This was an instance of tubal nephritis, of a subacute type, but involving so much of the secreting tissue of the kidney as to hinder the passage of urinary excreta; hence the uræmia and its usual consequences. In the early management of these cases there is probably no better plan than to give that simple and powerful diuretic, copious draughts of cold water.

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26. *Clinical Study of the Disease of the Kidneys in Scarlet Fever.*—Dr. L. THOMAS (*Archiv der Heilkunde*, X.) from observations made by him in eighty cases of scarlatina, has arrived at the conclusion that catarrh of the tubuli uriniferi does not occur in the same proportion in cases of scarlet fever, as does catarrh of the respiratory tubes in cases of measles. The two diseases do not resemble each other either in the regular occurrence in both of the catarrhal symptoms, or in the period of their appearance. Of his 80 scarlet fever cases, in 25 the condition of the urine was watched from the very onset of the disease. In 7 of these there was no appearance of albumen, but only of cylindroid formations, whilst there was an entire absence of any of the symptoms of catarrhal affection of the uriniferous tubuli, among which Dr. T. reckons the presence of a large quantity of opaque and degenerated epithelial scales, of blood, and of tubal casts. He observed as an exceptional occurrence, only the presence of albuminuria, in the early period of the disease, and then but to a small extent, and soon disappearing. In proportionately many cases, however, there may be observed, soon after the attack of scarlet fever, a slimy cloudiness in the urine,

that had been previously clear, and free from albumen, with an increase of epithelial scales, and sooner or later, single, cylindroid, elongated formations, true cylindrical casts being seldom present. When at the commencement of scarlatina albumen is detected in the urine, the latter will be found to contain, at the same time, more or less, unbroken epithelial scales, epithelial and hyaline cylinders, as well as cylindroid formations, with or without blood corpuscules. In such cases there was observable a gradual increase of the symptoms of nephritic disease during the course of the scarlatina.

On the presence in the urine of the cylindroid bodies, Dr. T. places much importance, believing that the specific process of scarlatina is to a certain extent the cause of their formation. From his observations he is convinced that they originate in the tubuli uriniferi by a transudation resulting from a pathological change of the epithelium of their tubuli. He recognizes four varieties of cylindroid bodies. They are either exceedingly pellucid, for the most part of considerable length, often fractured or corrugated, and perhaps forked; or they are broad, tolerably regular in size and form, and laid in longitudinal plaits, so as to present a striped appearance, and often split or fringed at the ends. At the same time they are often indented obliquely and twisted, as it were, upon their axes. Other cylindroids are somewhat smaller in size, and nearly as broad as the ordinary hyaline cylinder, without longitudinal folds or fringed extremities, with oblique depressions and fractures. The third variety of cylindroids is not so broad as the usual small hyaline cylinder, it is without longitudinal folds and fringed extremities, or with oblique depressions, with few apparent fractures, having somewhat the appearance of a narrow ribbon. Their contours are perfectly parallel. The distinction between these and the true cylinder consists chiefly in their greater delicacy and more considerable length. The fourth variety of cylindroid formation is marked by extreme fineness, and its fibriform appearance, as though it were formed out of the third variety by dividing this lengthwise into minute fibrilli. Between the different varieties of cylindroid formations and the proper hyaline cylinder, Dr. T. has seen the occurrence of complete metamorphosis, frequently a cylindroid body assuming the form of the hyaline cylinder.—*Centralblatt f. d. Medicinisch. Wissenschaft.*, April 30. 1870. D. F. C.

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27. *Pyæmic Inflammation of the Joints as a Complication of Scarlet Fever.*—Dr. J. K. Spender, in an instructive article (*British Medical Journal*, July 16, 1870), remarks that "this complication has been noticed by nearly every systematic writer on scarlet fever, though by many in such an imperfect way as to suggest that its importance was scarcely recognized. But the fact of morbid anatomy is that not only may there be a transitory inflammation of synovial membrane, but an inflammation prolonged and intense, leading to suppuration in the interior of a joint, and ultimately to erosion and destruction of the cartilages. In short, the joint no longer exists as such for physiological purposes, and, under the most favourable circumstances, the patient recovers with dislocation or deformity. The wrist-joints seem particularly liable to disease, and next to them the knee-joint and the hip.

"In the summer of 1863 I attended a scrofulous child severely ill with scarlet fever; the pyrexia was mild, but the wrists and right hip-joint became early and gravely involved, and after a time I discovered complete and irreducible dislocation of the head of the femur on the ilium. Besides these serious external lesions, a pulmonary abscess formed, which in a little while became a gangrenous vomica, and caused the incessant expectoration of fetid puriform matter. The poor child lived on in emaciation and suffering for nearly five years, and was killed at last by exhaustion and anorexia.

"Very lately I have attended another case of scarlet fever in the person of a young woman, the daughter of a wealthy tradesman, and nursed with every comfort. The illness appeared to be proceeding in a most favourable way, when one morning I found that the temperature had risen a degree and a half since the preceding evening. The wrists were swollen; and here I may speak of the importance of distinguishing a *bonâ fide* joint-swelling from that cutaneous œdema which often accompanies specific fevers; further, the hands could not be flexed without pain, and there was more general pyrexia. The treatment was so successful that in four days the local symptoms had entirely gone away, and the disease went on to a quick and happy termination.

"I have not noticed any special disturbance of the nervous system previous to the inflammation of the joints coming on. The thermometer affords a safe criterion of danger; it tells us that something approaches, the nature of which our sagacity must discover at the earliest possible time. * * * *

"The two trustworthy means in the treatment of the intercurrent affection of the joints in scarlet fever are: (*a*) the local application of heat and moisture, and (*b*) the administration of quinia. Foment the joint or joints with some hot medicated fluid; surround each with a layer of cotton wool; and place over this, again, a piece of oil-silk, which should be tied securely down above and below the joint, so as to protect it from all inquisitive draughts of cold air. Let this process be repeated morning and evening; in short, do just what you would do for a joint afflicted with acute rheumatism. Then, without discussing the large question whether quinia is a so-called "specific" in scarlet fever, or whether it may be safely trusted as the chief medicinal factor in pulling a patient through a dangerous adynamic stage, one thing appears certain—that this articular disease may with great advantage be treated with quinia, administered punctually and perseveringly. Here, again, we see a close analogy between scarlet fever and acute rheumatism. In the latter of the two cases which I have rehearsed, I began the use of quinia without delay; one grain was given in an ounce of acidulated water every three hours, night and day; and, the bowels having been previously moved with castor oil, no other medicine was prescribed. The fall of temperature was the first notable fact, and this was distinct and abrupt on the day after the treatment was begun; and, again, in twenty-four hours after this, the heat of body did not exceed the normal standard. Simultaneously, the development of local symptoms was arrested. A grain of quinia was administered every four hours for two days more, and so gradually left off. The convalescence was rapid and complete.

"Now, when we study the action of quinia in a case of this kind, we see how well it exemplifies the most recent ideas and facts of quinia-therapeia. The two new cardinal points about quinia are: (*a*) that it is an *antiseptic*, as shown by Dr. Binz in its power to prevent and arrest putrescence and fermentation; and (*b*) that it is an *antipyretic* or *antiphlogistic*, as demonstrated by Cohnheim in his experiments on the influence of quinia in inflammation of the mesentery of the frog. Further, the unquestionable power of quinia in acute rheumatism suggests the inquiry whether all inflammatory joint-affections may not be connected in a remote causal way with central nerve-lesion.

"If it be true that scarlet fever usually requires abundant support with a fair auxiliary amount of alcohol, this doctrine has special force when the joints are inflamed. Tissue-repair is gravely interfered with during the fevers of childhood; and when that interference is greatest, those structures suffer most in which growth is most active during health. It has been well said that "in the treatment of children's acute diseases the overwhelmingly important consideration, both with reference to present recovery and the avoidance of disastrous sequelæ, is *nutrition*."

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28. *Value of a Large Supply of Food in Nervous Disorders.*—Dr. G. F. BLANDFORD expresses (*Practitioner*, June, 1870) the belief that the unaided effects of food in the cure of nervous disorders have not had the trial they deserve.

"Certain chronic invalids," he says, "who have been brought under my notice have been lifted out of their former condition of 'nervousness' by a large increase in the quantity of their food. They have been people suffering from some general neurosis, taking the form of an insanity of a low and depressed character, or hypochondriasis, hysteria, alcoholism, or neuralgia, affections closely allied one to another, which may be witnessed in one form or other in individuals inheriting the same neurotic temperament. We may see different members of the same family displaying one insanity, another neuralgia, a third hypochondriasis, while the conversion of one variety into another is a matter of every-day observation. * * * *

"If we inquire into the past history of nervous patients, and have the opportunity of learning accurately the facts thereof, we often find that for a considerable time the supply of daily food has been in no degree adequate to the necessities of the individual. Here is a common case. A man somewhat past middle life, but whose years do not imply senile decay, becomes unfit for business, fidgety, irritable, depressed, or even melancholic to the extent of insanity. We hear that he has been a hard-working man of business, always nervous, and very probably an indifferent sleeper. Being most heavy for sleep in the morning, he has risen at the latest moment, and, snatching a mouthful of breakfast, has hurried off to catch the train or omnibus, worried and anxious lest he fail to reach his office at the hour appointed. At lunch-time, if he be really hard-worked, he takes, not a meal, but a sandwich or biscuit, eaten perhaps standing, and often bolted in so great a hurry that digestion is difficult; he tells us that he dare not take more of a meal in the middle of the day, for he would be rendered unfit for the remainder of his work. In the evening, with what appetite he may, he eats his dinner, perhaps not before half past seven o'clock. Now, granting that his dinner is amply sufficient, such a man lives on one meal a day with very little besides. These are the persons who cannot go on without frequent holidays; nervous by inheritance, they break down because they are insufficiently fed. A holiday, during which they live better, builds them up again for a time, again to break down; often to fall into the condition above mentioned. Another class among whom we may frequently witness the same result and corresponding symptoms are the clergymen who for various reasons deny themselves an adequate amount of food. Either they fast rigidly, according to the rule and doctrine of the day, often allowing some hours to elapse before they break their fast, or they think that hearty eating is a snare and a carnal enjoyment, or they hold it sinful to eat their fill while others are in want. Whatever the cause, certain it is that many of the clergy break down in one or other of the forms of nervous disorder already enumerated, and an enlarged dietary is to them a necessity. A vast number of women, for one reason or other, take a very small supply of food: some think it unladylike to eat heartily; some eat on the sly, and when this is not practicable go without. Many from the lives they lead are doubtless correct in saying they cannot eat because they have no appetite. These stay in the house from month to month, or never venture beyond the door except in a carriage, because ladies do not walk in the streets. Others have misgivings on the score of their digestion. Like many women who lead sedentary lives, and habituate themselves to passing long periods without action of the bowels, they suffer greatly from constipation, which is looked upon as an indication and a warning that they ought not to eat. So they starve themselves, and fancy that if they abstain from food it is of little consequence whether they pass a motion once a week or once a fortnight."

In low nervous depression, or meloncholia, he particularly urges the importance of full feeding. "It is not necessary," he thinks, "to adhere to a sick diet—to beef-tea or boiled mutton, to essence of beef or Liebig's food, or any other of the concentrations so loudly recommended. The ordinary diet-list of the individual in health may be given without hesitation—fish, game, poultry, meat, puddings, and the rest. His appetite should be stimulated by variety, and his dishes may be savoury as well as wholesome; but the supply must be large. Such patients for the most part have accustomed themselves to eat during the day a scanty and insufficient amount, and we shall be told that latterly they have not taken half their usual quantity. It is not too much to say that they require double that which they have so long taken; and as we shall not be able to induce them to eat double the quantity at a single meal, it will be necessary to multiply the number of the meals. Instead of breakfast, lunch, and dinner, two of which have probably been but the semblance of a meal, we may institute a series of feedings after this kind: first, something may be given early in the morning, before the patient gets up, as rum and milk, egg and milk, chocolate or *café au lait*. This will be useful in allaying the feeling of extreme depression and dispelling the gloomy and suicidal thoughts so constantly present on first waking. Next, breakfast may be taken. after dressing, and between it and the two o'clock lunch something else, as beef-tea or a sandwich. The dinner-hour should not be later than six, and at bedtime some light kind of supper should not be omitted. By this kind of division food may be administered six times in the day; and if the patient wakes in the night, and is restless and nervous, and disinclined to sleep again, food, taken even in small quantity, will often bring back sleep. With all this food may be given a reasonable amount of wine, or wine and stout, and this not by way of curing the disorder by stimulants, but because in conjunction with them less food appears to be required, and also because the addition of some wine or beer often renders the taking of the food more easy to the patient.

"Now the latter, and it may be the friends, will protest loudly that it is impossible to take this quantity: he will assign every conceivable reason for avoiding it; but if we are firm and insist, and, if necessary, cause him to be fed with a spoon, he will retain and thrive on it, and in a few weeks, or even days, will show very marked signs of its good effect. Patients have recovered under this treatment in a singularly rapid manner."

In alcoholism, both acute and chronic, especially the latter, the administration of nourishment in large quantity is highly necessary.

In hysteria and neuralgia he considers the same treatment required. Believing that neuralgia is one manifestation of impaired sensibility, as other neuroses may be displayed in mental symptoms, and in these alone, he thinks that the radical cure, and not the mere alleviation, is to be found in many cases in the supply of a large amount of nutriment to the nervous system.

In all chronic forms of neurosis, he considers alcoholic stimulants in any but the smallest quantity to be productive of evil rather than good. "In such disorders the fear, so commonly entertained both by doctors and patients, of 'overloading the stomach,' producing 'biliousness,' and the like, is in the majority of cases not realized when the plan of administering food in large quantity is tried."

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29. *Action of Hydrate of Chloral in Paralysis of the Insane and other forms of Insanity.*—The *Practitioner* for Aug. 1870, contains an interesting article on this subject by WM. MACLEOD, M.D., Dep. Inspector-General of Hospitals and Fleets. The following are his conclusions :—

1. That in paralysis of the insane, where the patients are destructive and violent, the judicious administration of chloral acts as an excellent hypnotic by night and soothing agent by day.

2. That under its action the patients have been free from destructive habits, and have gained in weight and strength.

3. That in one case as much as 2810 grains were taken during ninety-five days, the daily average taken being 30 grains. In a second case as much as 2435 grains were taken during 122 days, being at the rate of 22 grains daily; when the patient gave evidence of prostration. A third patient took 2380 grains during eighty days, the daily average being 28 grains with no bad symptoms. A fourth patient took 1362 grains during sixty-seven days, the daily average being 20 grains, with no bad symptoms. A fifth patient took 501 in twenty-four days, giving a daily average of 25 grains with no bad symptoms.

4. That under it the action of the bowels and bladder has improved.

5. That in no case has there been a refusal of food; on the contrary, the appetite of the paralytic patients increased.

6. That patients suffering from abnormal sensation derived much benefit from it.

7. That in patients subject to hallucinations of hearing, with suicidal tendencies, it has cut short the hallucinations.

8. That in patients liable to hallucinations of hearing, and under their influence becoming excited and noisy, it has produced calm.

9. That in patients with a propensity periodically to maim and hurt themselves, the desire has passed away under the influence of chloral.

10. That in patients who suffer incessantly from voices, it has been given with

partial benefit only. This refers to patients who were aware that the voices depended on morbid sensations.

12. In certain cases of melancholia benefit was derived from its administration, and convalescence advanced.

12. That in another case of melancholia with extreme depression, and the intellect being good, no permanent benefit was derived, except that under its administration the bloody exudation from the stomach completely disappeared.

13. That the greater the disorganization of the brain and cord (as judged by the symptoms, and especially by thermometrical observations) the sooner does the system come under chloral action.

30. *Treatment of Local Paralysis by Subcutaneous Injection of Strychnia.*—Mr. Barwell related to the Clinical Society of London (May 27) four additional cases illustrating his method of treating local paralysis by subcutaneous injection of concentrated solution of strychnia. Some of these cases were so managed as to serve experimental purposes. All solutions were of the strength of two grains to one hundred minims. Of these doses, beginning in the first case at one half-minim, and increasing in that and other cases to twelve half-minims, were employed. The first solutions had been neutralized by magnesia, in others the fluid was allowed to remain acid; in one case, injection of twelve half-minims was followed by general effects; in another, in which ten half-minims produced no general symptoms, the injection of seven half-minims into two different places was followed by slight twitching. From this Mr. Barwell argued that neither chloride of magnesium nor acid exercised any protective influence, but that the concentrated form of solution was the sole condition of safety, since the surface for absorption was so small. In all cases a certain amelioration, in one (besides that previously related) a very marked improvement, followed rapidly the use of the drug.—Dr. Buzzard mentioned the case of a patient in whom, a few days previously, the hypodermic injection of one-thirtieth of a grain of strychnia (*Pharm.* solution) had been followed by spasm of the jaws. —*British Medical Journal*, July 16, 1870.

31. *Treatment of Hæmoptysis.*—Dr. Dyce Duckworth discusses (*Practitioner*, Aug. 1870) the practice of treating hæmoptysis with styptic remedies and maintains that they may be dispensed with in favour of the following more simple plan.

"On the occurrence of continued hæmoptysis all other remedies should be withheld, and a simple astringent or slightly aperient medicine given. A good form is ♏x to ♏xv of dilute sulphuric acid, and, according to the state of the bowels, ʒss to ʒj of sulphate of magnesia may be given with this in some spearmint water every half-hour at first, and then less frequently. In addition to suitable posture (semi-erect), and other well-known favouring conditions, absolute silence should be enjoined, and the patient urged to refrain from coughing as much as possible. Should the bleeding continue, we should place a bladder of ice,[1] or a frozen compress,[2] between the scapulæ for a short time. This sometimes acts promptly, no doubt by reflex action, and probably this is the only means whereby a rapid change can be induced in the vascular walls. Should this fail, tinct. digitalis should be given (♏x or xv) with each dose of the astringent saline. In addition to this, if the case appears obstinate, a blister should be painted on the front of the chest, under the clavicle of the side believed to be affected.

"The ordinary habits and remedies may be resumed in a day or two after the cessation of the hemorrhage.

"The above description comprises the most beneficial method which I have witnessed, and, in setting it forth here, I need not say that there is no novelty in it. I do believe, however, that it deserves to be employed more frequently instead of the medication with opium and powerful astringents."

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[1] Walshe, Diseases of the Lungs, 3d edit. p. 427.

[2] Niemeyer, Text-book of Practical Medicine, Amer. transl. vol. i. p. 152.

32. *Bromide of Potassium in Ague.*—Dr. MOXON extols (*British Med. Journ.*, June 11, 1870) the efficacy of bromide of potassium in ague, and states he has used it successfully in two cases where quinia had failed.

33. *Somnambulism cured by Bromide of Potassium.*—Two cases of this are recorded in the *Gaz. Med. Venete;* one by Dr. B. LEVI, the other by Dr. PELIZZO. The subject of the first case was a married woman æt. 24, for ten years had two or three times a week paroxysms of somnambulism. Dr. L. gave her 2 grammes of the bromide daily. Under this treatment the attacks gradually became less severe and less frequent, and at the time of the report she had not had one for two months.

The subject of the second was a girl æt. 8, who so soon as she fell asleep would start up from her bed walk about her room, &c. One gramme of the bromide of potassium taken morning and evening immediately arrested her nocturnal walking.—*L'Union Médicale*, July 28th, 1870.

34. *On the Use of Arsenic in Certain Painful Affections of the Stomach and Bowels.*—Dr. ARTHUR LEARED, in an article on this subject in the *Medical Times and Gazette* (July 23, 1870), states that pain after food is a very common symptom of dyspepsia, and in many cases seems to constitute the disease. "This pain usually yields to medical treatment and proper diet. But there is another kind of gastric pain far more severe than that which depends on food, and which does not yield to ordinary remedies. I have elsewhere pointed out how this pain may be removed, and the subject seems of sufficient importance for some further remarks.[1]

In case of the stomach, the pain we have to deal with happens to the same individual at one time when it is full, at another time when it is empty. But cases are met with in which the presence of food in the stomach is clearly the exciting cause. The typical case is that in which there is pain independent of the act of digestion. In this form it commonly seizes the patient in the middle of the night, and is not preceded or attended by any dyspeptic symptoms. The pain in these instances, which are fortunately not very common, is extremely severe, and attended with alarming prostration, lowering of the heart's action, pallor, and cold perspiration. Brandy and other stimulants give but little relief, and after a period of agony, sometimes extending to several hours, the attack ceases as suddenly as it had commenced.

Persons of middle age who have been exposed to some great cause of mental depression are peculiarly the subjects of this affection of the empty stomach. Dr. Budd has also noticed mental disturbance as an exciting cause of the disorder, and he adds that "it is closely allied to water-brash." In this statement I do not concur, for without entering into the vexed question of the nature of water-brash, it is sufficient to say that a particular remedy which cures the one proves injurious to the other.

Further experience has taught me that the bowels, and especially the small intestines, are subject to the same kind of pain. I do not include colic from the effects of lead; but many cases of so-called colic unaccountably occurring at longer or shorter intervals are from the same cause. For whether the pain attacks the stomach or the intestines, its nature is the same; it is essentially neuralgic. Upon this circumstance the success of the new treatment, which consists in the judicious exhibition of arsenic, depends. As may be inferred from what has been stated, the difficulty of diagnosis between the neuralgic and the more common forms of gastro-intestinal pain is sometimes very great. The best rule of practice is, when gastric or intestinal pain resists all ordinary treatment, and cannot be traced to gall-stones or any organic source, to test the matter by the effect or non-effect upon it of the remedy. By this method I have succeeded in effecting several cures. On the other hand, the arsenical treatment has failed in two cases in which, so far as the diagnosis could be established, it ought to have succeeded. In both instances the patients were women past middle age, of stout habit, and too freely addicted to the use of alcoholic stimulants.

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[1] "The successful Use of Arsenic in certain kinds of Gastric Pain." (Read at the meeting of the British Medical Association at Dublin, 1867.) *British Medical Journal*, November 23 and 30, 1867.

The curative effects of arsenic are most striking in severe cases of paroxysmal pain, and its success becomes doubtful in proportion as the case assimilates to those in which a lower degree of pain is traceable to the influence of food. In determining the question of the fitness of a case for the arsenical treatment certain circumstances may render essential aid. If the disease came on after some mental shock or severe trial, if the patient has previously unmistakably suffered from neuralgia, if he has lived in a marshy district, and especially if he has had hemicrania or ague, and if, in addition to the occurrence of one or more of these circumstances, the pain is paroxysmal, it will almost certainly yield to arsenic. But as already said, there are other cases suitable for the treatment, and they are the most numerous, in which the pain closely resembles that which attends dyspepsia. It is sometimes extremely difficult to make the diagnosis between neuralgic pain of the stomach or bowels and the pain caused by gall-stones. But in my previous paper I have gone into details respecting this and other sources of error.

A few words will suffice as to the particular preparation of arsenic to be selected, and the extent to which it should be used. In most cases the liquor arsenicalis answers every purpose, but when the system is more than usually susceptible of the action of the mineral, the liquor sodæ arseniatis seems to irritate less, and in a few instances the acid solution of arsenic is to be preferred to either. Whatever preparation be selected it should always be taken immediately after food, and, notwithstanding that its beneficial action may have been previously observed, it will be proper to continue the medicine until its constitutional effects are well marked. Notwithstanding what has been said to the contrary, I do not believe that the proper use of arsenic as a medicine is followed by any injury to the system.

35. *Therapeutics of Chronic Constipation.*—Dr. J. K. Spender, in an instructive paper on the treatment of constipation when it exists *per se* as a primary disorder of function, recommends the following judicious plan, which comprises four factors: (*a.*) Minute and frequent doses of watery extract of aloes, not exceeding 1 gr.—very rarely, of extract of colocynth. (*b.*) A dose of sulphate of iron, gr. iss to gr. ij, *always combined* with the aperient. (*c.*) Regulation of the diet. (*d.*) Constitutional exercise. He does not believe that any other drug can supply the place of the sulphate of iron, though belladonna may be occasionally useful as an auxiliary. At first he gives a pill, composed as above, three times a day, immediately after the principal meals, and gradually reduces the number and frequency of the pills as the intestinal functions are restored. The action is slow, requiring two, or perhaps three, days, but *nothing approaching to purgation* ought ever to be permitted. As a substitute in certain cases, Mist. ferri co., with dec. alöes co., in corresponding doses, may be adopted.—*Med. Times and Gaz.*, Feb. 19, 1870.

36. *Infusion of Mustard in Obstinate Hiccup.*—Dr. Jauariz reports (*Siglio Medico*) a curious case of obstinate hiccup cured by the internal administration of an infusion of mustard. A Spanish physician was seized, while convalescing from a gastric fever, with obstinate hiccup, which gave him no rest. For sixty hours, the patient was treated with antispasmodics, narcotics, ipecacuanha, and revulsives, without effect. He then besought his wife to give him some linseed tea—she by mistake gave him an infusion of mustard. Of this the patient drank a cupful at once, and was surprised to find his hiccup cease, not to return. This physician profited by the lucky mistake of his wife, and subsequently treated with success many obstinate cases of hiccup. The dose which he employed was one teaspoonful to four ounces of boiling water. The author of the article in the *Siglio* had also successfully employed the infusion of mustard in three cases of obstinate hiccup which had already lasted many days. In the *Gazette Médico-Chirurgicale de Toulouse*, a case is related of a governess who had been treated for hiccup during twenty days with every variety of antispasmodic—

ether, belladonna, valerian, etc.; laudanum was the only thing which gave any relief, and enabled the patient to retain some nourishment. At last, recourse was had to the infusion of mustard: one teaspoonful of flour of mustard was infused for twenty minutes in about half a pint (250 grammes) of boiling water, it was then filtered, and given to the patient, who swallowed it at one draught. The troublesome affection ceased at once and never returned. Cases of obstinate hiccup are sufficiently frequent and intractable to make practitioners grateful to us for pointing out to them a remedy so efficacious and so accessible as infusion of mustard seems to be.—*Révue de Thérapeutique Médico-Chirurgicale*, 1st June, 1870.

37. *Cannabis Indica in Menorrhagia and Dysmenorrhœa.*—Dr. A. SILVER extols (*Med. Times and Gaz.*, July 16, 1870) the powers of Indian hemp in menorrhagia and in dysmenorrhœa, and relates several cases illustrative of its efficacy. He says it is efficacious, not only in merely functional menorrhagia, "but even in those instances where there is local mischief in the shape of tumours or malignant disease, the hemp still asserts its influence over the sanguineous discharge, but only for a time. Upon the whole, therefore, if the hemp given repeatedly, each time arresting the discharge and relieving pain, but when omitted these again recur, there is just cause to suspect the existence of uterine mischief other than merely functional disturbance. Thus, in a case of uterine fibroid tumour of great size, rising nearly to the umbilicus, and, of course, elongating the body of the uterus, the periodic flow was greatly increased, and the patient was consequently much weakened; even here the hemp proved satisfactory in arresting the discharge, but not in preventing its recurrence. In another instance, where the discharge proved intractable, a small polypoid growth was discovered, and removed, to the relief of the patient."

In painful menstruation, not being mechanical, he regards it as most useful, and states that Dr. Hunt has given it in one hundred cases, and had never known it to fail after the third dose in relieving pain and discomfort. Dr. S. usually prescribes the tincture in twenty minim doses, and says it is best given with aromatic spirit of ammonia.

38. *Rhinoscleroma.*—HEBRA states (*Wien. Med. Wochenschr.* 1870) that in four men and five females he had observed a very peculiar sclerosis of the skin of the nose, the forehead, the cheeks, and upper lips, in the form of a strictly circumscribed deciduous projection, having a smooth surface, and either corresponding in colour with the normal hue of the surrounding parts, or having a darker shade, a brownish-red tint, and of a density often equal almost to that of ivory. These prominences are most commonly free from pain; when sensible upon pressure they are very rapid in their development. They are never accompanied by any changes in the neighbouring parts referable to inflammation. A microscopic examination shows that in the morbid growths referred to (COHN), the epidermis presents no change. The papillary body and adjoining layer of the corium are greatly thickened within strictly circumscribed limits. Throughout the diseased portions there exist, imbedded in the meshes of the cellular tissue, small nucleated cells; these occur more especially around the bloodvessels. Along with these there may exist also in the deeper-seated layer of the corium, a similar condition of things, or even when the upper layer is not implicated or the subjacent fat tissue. Of the sebaceous follicles and perspiratory exhalants, within the diseased parts, no trace remains. The bulbs of the hair remain unchanged. As the cells above described as occurring in cases of scleroma have always a recent appearance, and undergo no retrogression, M. Hebra believes that the next change would be into *gliosarcoma*. He further remarks that when the scleroma, in the cases described, was destroyed by the application of caustic potash, after the lapse of six months, there was no recurrence of the disease. From none of the other therapeutic measures resorted to was any benefit derived.—*Centralblatt f. d. Medicins. Wissenschaft.*, April, 1870.

In the *Allgem. Wien. Med. Zeitung.* 1870, occurs an article from Dr. WEIN-

LECHNER on the same affection as that described by HEBRA. It presents, however, no additional facts of any importance.—Vide *Centralblatt* for May 7, 1870. D. F. C.

39. *On the Anatomy of a Case of Molluscum Fibrosum.*—Dr. C. HILTON FAGGE read a paper before the Royal Medical and Chirurgical Society, based on the results of the dissection of portions of the integument of a woman, aged forty, affected with molluscum fibrosum, who died in Guy's Hospital of another disease. The author examined some of the most minute tumours—scarcely bigger than pin's heads—by dissecting them out of the cutis, and submitting them to a low power of the microscope. An independent examination of some of the larger growths was made by his colleague, Mr. H. S. Howse. These were hardened in chromic acid, and fine sections of them were viewed with higher objectives.

The conclusions arrived at by the author and Mr. Howse were as follows: 1. Each tumour is originally developed round a hair-follicle, inclosing at the same time the sebaceous glands belonging to the follicle. 2. The smallest tumours consist of two distinct elements; a central glandular body, itself surrounding a hair; and a peripheral mass of very fine connective tissue, containing numerous minute oval nuclei. 3. The glandular body is a sebaceous gland, enlarged by the separation of its sacculi from one another, and perhaps also by the actual multiplication and increase in size of the sacculi themselves. 4. The peripheral mass of nucleated connective tissue is developed from the two external layers of the dermal coat of the hair-follicle and sebaceous glands. The structure of one of the smallest tumours was shown in the microscopical drawing which accompanied the paper. The centre of the tumour was occupied by a hair, surrounded by a beautifully branching glandular body, itself inclosed in a translucent fibrous mass.

A coloured drawing illustrated the appearance of the under surface of a portion of integument affected with molluscum, when it has been dissected so as to expose the numerous soft red tumors scattered throughout its substance.

The latter part of the paper was devoted to an examination of the literature of molluscum, and of the views propounded by previous writers. The only observations irreconcilable with the author's were those published in the year 1858 be Förster.

In conclusion, it was maintained that the author's investigations rendered the name "molluscum fibrosum" a more appropriate one for the disease under consideration than that of "fibroma molluscum" used by Virchow and other German writers.—*Brit. Med. Journ.*, July 30, 1870.

40. *Stenosis Arteriæ Pulmonalis.*—Dr. NOBILING, in the *Bair. Aerztl. Intell. Blatt*, 1869, states that in a child which was completely cyanotic, and died on the fourth day after birth, the heart was found to be double its normal size from concentric hypertrophy of the right ventricle. The cause of this inordinate enlargement was found to be a very high degree of stenosis of the mouth of the pulmonary artery, with considerable thickening and rigidity of the semilunar valves. Both the foramen ovale and the septum ventriculorum were open. The ventricles were unusually light-coloured towards the apex of the heart.—*Centralblatt f. d. Med. Wissensch.*, March 26, 1870. D. F. C.

41. *Case of Essential Dropsy.*—Dr. A. WERNICK relates (*Deutches Arch. fur Klin. Med.*, 1870) the case of an unmarried female 22 years old who, during convalescence from a febrile disease of some weeks' duration, became affected with œdema of the lower extremities, and shortly afterwards with swelling of the abdomen and difficulty of respiration. After her admission into the hospital the existence of hydrothorax was made out. No disease of the heart could be detected—the urine was without a trace of albumen, and by the aid of the microscope nothing abnormal could be detected in the blood. There was increased sensibility of the skin throughout almost every portion of the body, while its temperature was reduced to almost its lowest degree. The thorax was twice punctured to allow of the discharge of the effused fluid it contained, which

gave to the patient great relief. Soon, however, intense cyanosis and somnolence set in, and were quickly followed by death. Upon a *post-mortem* examination, no trace of any lesion adequate to the production of the dropsical effusion could be detected, hence Dr. W. concludes that the case is to be viewed as one of those rare forms of dropsy which is dependent solely upon a disturbance in the function—a decreased activity—of the cutaneous exhalants, and that confessedly, in the treatment of the case described by him, a well-known variety of this form of dropsy had been entirely overlooked. D. F. C.

SURGICAL PATHOLOGY AND THERAPEUTICS, AND OPERATIVE SURGERY.

42. *Results of the Greater Amputations.*—Mr. SPENCE read before the Medico-Chirurgical Society, Edinburgh (July 6, 1870) an interesting communication on this subject. It was founded on the results of his own practice only, and included 403 cases. The paper was illustrated by very extensive tables, showing the causes which rendered the amputations necessary, and the results of each. The tables are far too long to be reproduced here. The first one gives the general results as follows:—

	Total.	Recovered.	Died.
Hip	9	3	6
Thigh	155	100	55
Knee	1	0	1
Leg	53	37	16
Ankle	82	76	6
Total lower extremity	300	216	84
Shoulder	23	17	6
Arm	33	21	12
Forearm	43	35	8
Wrist	4	4	0
Total upper	103	77	26
Grand total	403	293	110

After some general remarks on the dangers of amputation, Mr. Spence pointed out how in many cases the *circumstances* of the case, rather than the operation itself, are the causes of death. The most familiar example of what he meant was to be found in strangulated hernia, in which the operation itself was nothing, but the delay of the operation often made it fatal. Hence the importance, in all statistics of amputations, in mentioning the disease or injury for which the operation was performed. He then analyzed the causes of death in primary amputations, under different heads: 1. Additional injuries; 2. Shock; 3. Loss of blood; 4. Gangrene of stump; 5. Pyæmia. He then illustrated the difference in result of operation for accident and operation for disease, by the results of his own amputations of the leg. Of thirty-one cases for accident, sixteen recovered, fifteen died; of twenty-two cases for disease, twenty-one recovered, one died. Of seventy-nine amputations of the thigh for disease, sixty-seven recovered, and only twelve died. And his impression was, that the most of those that died were cases of amputation on account of gelatinous disease of the knee-joint. He observed that amputations for necrosis were much more fatal than those for joint-diseases, and advised delay in cases of acute necrosis. On the mode of operating, Mr. Spence observed that, while for disease of joints he advised the operation by a long anterior flap, with a little muscle to cover the end of the bone, with a short posterior one, he advised, in cases of accident or malignant disease, the use of two equal flaps, or